



Date:

Caseworker:

Office address and phone number:

Name and address of client or authorized representative.

We need proof that you received medical equipment.

(Receipt of durable medical equipment.)

Name of client:	Client number:
Name and address of place of care where client lives:	
Name and address of the place where the equipment came from (the durable medical equipment provider):	

We need to know if you received _____.

If you received this item, we can take the cost off (deduct) what you pay for nursing care. This is called an “incurred medical expense deduction.” We can’t do this until we get this form.

Did you get the equipment?

We need to make sure you got this item. Fill out the following:

☐ Yes, I have the item listed above. It was delivered on ____ / ____ / ____.

Date (mm/dd/yyyy)

☐ No, I didn’t get the item listed above.

Sign and date:

_____ Signature – Client or Authorized Representative	____ / ____ / ____ Date (mm/dd/yyyy)
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